MORRIS PLAINS BOARD OF EDUCATION
INSURANCE BENEFITS INQUIRY FORM

Employee Name: _____ **Employee ID#:** _____
Address: _____
Work Phone #: _____ **Home Phone or Cell #:** _____
Email Address: _____
Employee Date of Birth: _____ **Employee Soc. Sec. #:** _____
Patient Name: _____ **Patient Date of Birth:** _____
Coverage in Question **Direct Access:** _____
Delta Dental: _____
Name of Provider(s): _____
Date(s) of Service: _____
Dollar Amount of the bill(s): _____

Please give a description below of the reason for the inquiry and attach any additional information such as the bill from the provider or the explanation of benefits from the carrier. Please be sure to complete the top portion of this form in its entirety.

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Mail, Fax, Email or Phone*
Pat Eckel
RHM Benefits, Inc.
1001 Route 517, Suite 1
Hackettstown, NJ 07840
Phone: 908-852-0222
Fax: 908-852-0013
Email: peckel@rhmbenefits.com

Fax or email is most effective. Please remember to include all pertinent information.